MinnesotaCare® Fact Sheet

DHS-3086 (7-97)

In response to the growing number of Minnesota residents who don't have health care coverage, the 1992 Minnesota Legislature created a subsidized health program called MinnesotaCare, open to all Minnesota residents who meet program and income guidelines. The program is funded by enrollees' premiums and statewide taxes. MinnesotaCare is administered by the Minnesota Department of Human Services.

Eligibility

- Minnesota resident (if over 21 and no children, you must have lived here six months)
- Must have a Social Security number.
- Not currently insured (includes Medicare) or covered by other health insurance in the last **four months.** Exemptions: low-income children and people whose Medical Assistance (MA) benefits are ending
- No access to employer-paid health insurance (50% or more) for **last 18 months.** Exemptions: low-income children and some adults
- Must meet income guidelines. Figures (below) based on 1997 federal poverty guidelines

Families & Children under 21*

Family Size	*Income Limit (Monthly Gross)*
2	*$2,431*
4	*$3,678*
6	*$4,301*

**A pregnant woman counts as two people.*

Singles/Couples (over 21)

Household Size	*Income Limit (Monthly Gross)*
1	*$1,151*
2	*$1,547*

Copayments

- Adults (21 years and older) pay:
  - $3 for each prescription medication
  - $25 for each pair of eyeglasses
  - 10% of inpatient hospital costs (up to $1,000 per health plan per adult, $3,000 per family)
- Children and pregnant women make no copayments

Services Covered

- Doctor and health clinic visits
- Inpatient hospital services *
- Dental care for children and pregnant women; preventive care only for other adults
- Immunizations
- Vision care and prescription eyeglasses (restrictions apply)
- Most prescription medications
- Laboratory and X-ray services
- Mental health services
- Alcohol and drug dependency treatment (inpatient and outpatient)
- Home care services
- Chiropractic services
- Rehabilitative therapy services
- Hospice care services
- Ambulance (emergency use only)
- Emergency room services
- Medical equipment and supplies

** No limit for children under 21 and pregnant women. No limit for adults who have a child in their home and whose income is equal to or less than 175% of the Federal Poverty Guideline. All other adults have a limit on inpatient hospital of $10,000 per health plan. Adults who are not pregnant also have a 10% copay (up to $1,000 per health plan per adult, $3,000 per family). No limit or copay if eligible for MA. Admission to hospital may result in a requirement to apply for MA.*

Services Not Covered

MinnesotaCare does **not** pay for past medical bills. If you are over 21 and not pregnant, MinnesotaCare will **not** pay for the following services*:

- Adult nonpreventive dental services
- Personal care attendant services
- Nursing home or intermediate facilities care
- Private duty nursing services
- Non-emergency medical transport
- Case management services

These services **are covered for children under age 21 and pregnant women.*

Premium Costs

- Enrollees pay a monthly premium based on family size, the number of people covered, and income. Some low-income children pay a fixed premium of $4 a month per child.

Families

Gross Monthly Income	*Family Size & Number Covered* 2	4	*6 or more*
$1,000	$16	$20	$28
$2,000	$148	$59	$57
$3,000	Not eligible	$222	$144

Singles/Adult-Only Households

Gross Monthly Income	*Single person*	*Couple (2)*
$1,151	$55	$36
$1,547	Not eligible	$74

Provider Information

- MinnesotaCare pays a monthly fixed fee to contracted health plans for health care delivery.
- Enrollees choose a health plan when they enroll. They get all health care services — providers, clinic, dentist, pharmacy, hospital — from that plan.

How To Apply

- Call **1-800-657-3672 (toll free) or 297-3862** (Twin Cities Metro). For TTY, contact Minnesota Relay Service at 1-800-627-3529.
- Applications are also available from schools, clinics, and social service agencies.

If you ask, we will give you this information in another form, such as Braille, large print or audiotape.

Minnesota Health Care Programs

Health Insurance Information Form (HIIF)

Please complete this form if you:

- currently have insurance (MA/GAMC and MinnesotaCare applicants),
- had insurance through an employer in the last 18 months, or
- were offered insurance by an employer in the last 18 months and refused it.

} (MinnesotaCare applicants only)

If you do not answer these questions completely, your application may not be processed. You may need to contact an employer to complete the information.

A. SKIP TO THE NEXT PAGE: If you *currently* have insurance (you answered *yes* to question 16A on the Minnesota Health Care Programs Application). If you are unsure of what type of coverage you have, there are definitions of some coverage types on the back of this page.

B. FILL OUT THIS SECTION: **If you are applying for MinnesotaCare and you had health insurance through an employer in the last 18 months and it has now ended, or if health insurance was available to you from an employer in the last 18 months and you refused it** (you answered *yes* to questions 18A or 18E on the Minnesota Health Care Programs Application). Attach another page with this information if you had more than one job in the last 18 months.

1. How much would or did **the employee** pay for the insurance?
   Individual coverage: $)_____ per ☐ month ☐ 6 months ☐ year other (explain)_____
   Family coverage: $)_____ per ☐ month ☐ 6 months ☐ year other (explain)_____

2. How much would or did the **employer** pay for the insurance?
   Individual coverage: $)_____ per ☐ month ☐ 6 months ☐ year other (explain)_____
   Family coverage: $)_____ per ☐ month ☐ 6 months ☐ year other (explain)_____

3. What date did the insurance end or the employer stop paying for the insurance? _____

C. FILL OUT THIS SECTION: **If you are applying for MinnesotaCare and your insurance ended because your job or the policyholder's job ended. The policyholder is the person who had the insurance through an employer.**

When the job ended, did the employee qualify for unemployment benefits? ☐ Yes ☐ No
If no, use this space to explain why you or the policyholder left the job, or why the job ended.

_____

_____

_____

_____

_____

_____

_____

If you ask, we will give you this information in another form, such as Braille, large print or audiotape.

COVERAGE TYPES

- **Basic Hospital Insurance**
  Pays for all services provided while in the hospital on an inpatient or overnight stay basis. Usually has co-payment and/or deductible.

- **Medical-Surgical Insurance**
  Pays for laboratory, X-rays and surgery done in the office or clinic. Also pays for doctor visits to a patient in the hospital and anesthesia services. Usually has a maximum amount that it will pay each year.

- **Dental Insurance**
  Pays for necessary services provided by dentists, orthodontists, and oral surgeons.

- **Vision Insurance**
  Pays for services provided by eye doctors (optometrists and ophthalmologists), including eyeglasses.

- **CHAMPUS**
  For people who are in the military service, their dependents, and some retirees and their dependents.

- **Prescription Drug Plan**
  Pays for prescription drugs except for a co-payment on each prescription.

- **Health Maintenance Organization (HMO) Insurance**
  A prepaid system of health care for which members must use services and facilities of that HMO.

Third Party Liability Resource Information

The purpose of this form is to collect information about health insurance available to you or members of your family Please complete this form. If you choose not to, you or your family members may be denied coverage.

1.

SELF:

2. INSURANCE *POLICY* INFORMATION

POLICY NUMBER:	POLICY BEG DATE:	POLICY END DATE:

3. INSURANCE *COMPANY* INFORMATION

COMPANY NAME:			
CLAIMS ADDRESS	CITY	STATE	ZIP

If there is a deductible, how much is it? $_____ per ☐ family ☐ person

4. COVERAGE TYPES (Circle all that apply):

01	Basic Hospital	08	PPO (Preferred Provider Organization)	15	Cancer
02	Medical-Surgical	09	CHAMPUS	16	Accident
03	Medicare Supplement Policy	10	Dental (Comprehensive)	17	Indemnity
04	Prescription Drugs with Deductible	11	Dental (Preventive Only)	20	Over the Counter Drugs (OTC)
05	Prescription Drugs with Co-Payment $_____ Co-pay	12	Eyeglasses/Vision Care	21	Veteran's Administration (VA)
06	HMO	13	Nursing Home	24	Dental PPO
07	HMO (Medicare)	14	Hospital/Surgical Only		_____

5A. EMPLOYER/GROUP INFORMATION - *Policy Type:*

Employer/Group Name ☐ (Complete this section) Individual ☐ (Go to 5B.)

GROUP NUMBER:	EMPLOYER/GROUP:		
STREET ADDRESS	CITY	STATE	ZIP

5B. POLICYHOLDER INFORMATION

ID# *(IF POLICY HOLDER IS ENROLLED)*:	NAME (LAST, FIRST, MI):		
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE #:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	

5C. INDIVIDUALS COVERED BY POLICY (List all if applying for or covered by assistance programs)

Office Use PMI	**Name**	POLICY BEGIN DATE	END DATE	**Relationship to Policyholder** (Self/Spouse/Child/StepChild/Other)

If you ask, we will give you this information in another form, such as Braille, large print or audiotape.

Minnesota Health Care Programs
Health Insurance Information Form
IMPORTANT INFORMATION

We need this information to decide if you have other insurance or help from the government that would pay for your medical bills instead of Minnesota Health Care Programs. We are required by law to ask you these questions. You are not required to give us the information. If you do not, we may not be able to help you right away. All the information you give us is private. In order to do their jobs, these people will be allowed to see the information you give us: Minnesota Health Care Programs staff, Human Services Benefit Recovery staff, your employer, your insurance company or the government program that helps you, your child, your medical provider, your spouse, or absent parent of your children. You will be asked for your permission for anyone else to see this information. Please tell your worker of any changes in your insurance within 10 days. Your signature on the Minnesota Health Care Programs application allows us to collect payment from your insurance company or government program for bills paid earlier by Minnesota Health Care Programs.

Directions:

Please answer the questions on this form for all health, dental, vision and accident insurance which covers you or your children.

If you are covered by more than one type of insurance, fill out one form for each type. You can get more forms from MinnesotaCare or your worker.

Please answer every question accurately. BE SURE TO PRESS HARD.

If you need help with this form, call 297-3862 (Twin Cities metro) or 1-800-657-3672 (Greater Minnesota) for MinnesotaCare. Call your county agency for help if you are applying for MA/GAMC.

1. Print your last name, first name and middle initial in the box provided. This information must be the same as the "self" information listed in the Minnesota Health Care Programs application.

2. Print the insurance policy number.
Print the date the insurance coverage started. Leave the End Date box empty. This is used only if you stop carrying this insurance.

3. Print the full name of your insurance company and the full address of the office that takes care of your health, dental, accident, or other medical claims or bills.

4. Circle the types of coverage provided by this insurance. If you have dental and/or vision insurance or an accident policy with a different company, call MinnesotaCare or your agency, and we will send you another form.

5A. Check (X) if this insurance is a group policy or an individual policy.
If it is a group policy, print the insurance company's full name and address. If you do not know the address, print "UK."

5B. If this is an individual policy, print the information in the boxes provided. The policy holder is the person in whose name the policy appears.

5C. Print the first and last name of each person who is covered by the insurance and who you also want to be on Minnesota Health Care Programs. Write the relationship of each person to the policyholder. LIST ALL COVERED FAMILY MEMBERS. If there are more than five family members covered by the insurance and you want them all to be on Minnesota Health Care Programs, please list their names on a separate piece of paper and send it with this form.

This form has important information about State Health Insurance. If you do not understand it, get help now.

Esta forma contiene información importante acerca del Seguro de Salud del Estado. Si no la entiende hágala traducir inmediatamente.

Daim ntawv no muaj lus tseem ceeb hais txog cov ntawv kho mob huav State Health Insurance. Yog koj tsis to taub, koj nriav neeg pab.

Trong tai liệu này có nhưñg điêù quan trọng bạn câǹ biết về Chuong Trình Bao Hiêm Sức Khoe cua tiêu bang Minnesota. Néu bạn không hiêu rõ, xin hoi thêm chi tiết ngay.

ជំនួយសុខាភិបាលនិងគំរោងសុខភាពនៃរដ្ឋមីនីសូតា

ພອມນີ້ມີຂໍ້ຄວາມທີ່ສຳຄັນ ກ່ຽວກັບປະກັນໃນສຸຂພາບຂອງຣັຖ ຖ້າທ່ານບໍ່ເຂົ້າໃຈ ຈົ່ງຂໍອກຄົນແປໃຫ້ທ່ານ